Physical Medicine
NEWSLETTE R
October-December 2004
Volume 2004, Number 1,
Page 1

Physical Medicine Occupational Therapy — United States Air Force Physical Therapy — Combining to Better Serve You

News

Promotions

Congratulations to the following Lt Col Promotes:

Maj Mark Lange
Maj Mark Armstrong
Maj Stephen Stoecker

2003 ANNUAL AWARD WINNERS FOR PHYSICAL MEDICINE

Field Grade PT of the Year
Major Oluwanishola Asenuga
Sheppard AFB TX

Company Grade PT of the Year
Captain Denis J. Nolan
Holloman AFB NM

Field Grade OT of the Year
Major Peter D. Reinhardt
Lackland AFB TX

Company Grade OT of the Year
Capt John A. Dalomba
Lackland AFB TX

The Colonel Gary Wasem Physical Medicine Team Award

USAFA Physical Therapy Element
Sr Officer: LtCol Gary D. Sherwood
Sr Enlisted: MSgt Brenda L. Parker
Major Randy Green
Major Laura Fields
Capt Joseph Vance
Capt Eric Wilson
Capt John McGee
TSgt Tracy Atkinson
SSgt Matthew Bowen
SSgt Johnathan Gamer
SSgt Jessica Rivera
SSgt Martin Vicente
SSgt Emilia Rodriguez
SSgt Alisa Davis
SrA Jay Villanueva
SrA Maybelle Mckinney-Martin

Words From Our USAF SG Consultant

Col Jim Calhoun

Good day to all of you. I have finally arrived at Travis. So first let me officially thank Col Eva Eckburg for assisting me over the past 8 months, while I was the Group Commander at Vance. She did an awesome job as our Associate Chief, and finally as my fill-in. She handled the tough issues with ease, and we and especially me…owe her a lot, so again Col E. thank you so much. You're a tough act to follow.

Allow me this opportunity to tell you, that you're doing a great job at your respective MTFs, AFIT and career broadening assignments. You have built an outstanding reputation. I am overwhelmed with phone calls and emails from Sq and Group Commanders concerning the fantastic things that you're doing out in the field. So please keep my phone ringing!

My expectations are fairly simple; continue to push the envelope in regards to patient care and readiness, enhancing your clinic's efficiency, research, and mentoring your peers and subordinates. I fully expect Element Leaders and Flight Commanders to be fully engaged in patient care. Yes, I understand that we have/need additional duties, but should not come at the expense of patient care. Let me be more specific, if you are a flight commander, my expectations are that as a minimum you see half the number of patients of your most productive therapist. If your clinic has to refer patients downtown, then my expectations are that you disengage from your additional duties and see your patients.

Ok, now that I'm on a roll let's discuss career-broadening assignments. First, not everyone is going to get one, second they are not to be used as a means of "getting" out of the clinic. And if you're fortunate to get a career broadening assignment, my expectations are that you maintain your clinical skills and continue to see patients at the nearest military MTF if logistically possible. Typically career-broadening assignments will only occur once in your career.

Take time to establish goals; both personal and professionally. If you're a supervisor, know what your subordinate's goals are. Goals should be realistic, not everyone wants to be a commander, researcher, staff officer, or a CMSgt . You can be r[illegible]hiefs; i.e. Cols Lorraine Shelton-Gaines, B[illegible]eney. Part of my job is to groom r[illegible]possibly the first BSC general…yes, one of you! Or groom the next CMSgt! I have an open door, call or email me anytime. Again, I'm looking forward to working with you.

Don't Forget to Get Out and Vote!

NEWS

2003 Physical Medicine Enlisted Award Winners

Physical Medicine Airman of the Year
SrA John P. Lauricio
Keesler AFB MS

Physical Medicine NCO of the Year
SSgt Kimberli A. Kirkland
Sheppard AFB TX

Physical Medicine SNCO of the Year
MSgt Tyrone F. Davis
Sheppard AFB TX

Orthotic Airman of the Year
SrA Amanda R. Thomason-Isaac
Yokota Air Base, Japan

Orthotic NCO of the Year
SSgt Amy K. Baker
Yokota Air Base, Japan

No Orthotic SNCO nominee.

Introduction To The New Enlisted Career Field Manager

Chief Xavier Springs

I can't begin to tell you how pleased and excited I am to accept the role as your Career Field Manager. It means so much to me to know my senior leadership, peers, and subordinates have the confidence in me to lead our enlisted force. Before I proceed, I must first give a "shout out" to Chief Murray, who expertly steered our career field through numerous enlisted challenges over the past few years.

As for current PM issues, I know most of you are wondering about the military-to-civilian conversions and the balance force initiatives. The Air Force is looking at several initiatives in order to get our overall manning at the appropriate level (we are a little less than 20,000 over our Air Force limit). These are just two studies of many currently being reviewed by the Air Force. At this point in time, the initiatives are just a study so don't fret. I have tasked your MAJCOM Functional Managers to provide me with data for these studies, so please respond quickly and as accurately as possible to their requests. I have a deadline of 5 November 2004 to compile and submit the collected data.

Speaking of MAJCOM Functional Managers, they are there to serve you and are excited about doing so. They are armed with a plethora of knowledge, such as cross-training options, assignments, and manning issues; however, they can't serve you if not given the chance. I encourage you to communicate with your MAJCOM Functional Manager on a regular basis.

Lastly, there are a few issues we need to address right away. First, stop pronouncing yourself as physical therapy or occupational therapy technicians. I have been hearing this too much. We are PHYSICAL MEDICINE TECHNICIANS! If you haven't been properly trained to perform as a PM technician, I employ you to get the training completed today. Remember, when you PCS or deploy, you are expected to have the knowledge and ability to perform as such.

Secondly, we have several people matrix to sections outside of PM. Keep in mind, if this ground and you aren't officially released from the career field, your PM flight won't receive a body to replace you. Due to current and projected manning, being released from the career field is overly impossible. The approving authority for any releases from the career field is AFPC, not yourself. I ask please take care of home (4J0X2s/4J0X2As) first. As I have stated several times over the past month, if a flight can afford to PCS a body to other sections, why not PCS that body to another PM clinic who needs the manning to perform daily flight duties.

Finally, we need some sharp troops to cross-train into the Orthotics' shred. According to Air Force metrics, Orthotics needs an average of three new recruits per year to maintain a satisfactory manning level. Due to our merger, only 4J0X2s are eligible to fulfill these slots. So I say again, let's take care of each other. This is an excellent opportunity and if interested, contact SMSgt Preston Madler, 4J0X2A Subject Matter Expert.

I truly look forward to serving with and for you. My phone lines are always open, so feel free to contact me at any time. Be proud of what you do and let everyone around you know it. Together, we will continue to make great strides!

Final Remarks From The Former AF Physical Medicine Career Field Manager

Chief Octavia Murray

My tenure as CFM has been a huge learning experience…when appointed, I didn't know what the CFM responsibilities entailed and many times felt like a salmon swimming upstream…except many times it seemed I just wasn't moving.

There were so many Air Staff taskings, and so many facets of the career field management that I had direct oversight/input…there was no training…but I learned a lot!

And, I know my learning curve has been painful for you too. Sorry for the short notice taskings…I found myself defending our career field's existence and our manning numbers time and time again and your help through the years has been essential.

Just as I stepped into the CFM position, although some groundwork had been laid, I was thrust into the merger process. You wouldn't believe the coordination and number of fingers in the pie to accomplish this feat…the trick to coordinating this daunting task…be honest, tell "the powers that be" your challenges…most of my conversations started like this, "Hello, I'm Chief Murray, the new CFM for PM…I'm ignorant, I have no clue what I'm doing"…

But, congratulations to you all…we completed our merger in just 1 ½ years…the 4N/F/E merger was in the works for over 5 years before they were implemented…you guys are absolutely phenomenal!

The folks at our schoolhouse have done a great job. I didn't realize the CFM involvement with them…but the career field literally begins with them. We have and had the great fortune of having the finest staff in AETC. Their knowledge, passion, and dedication is par to none…you guys are awesome.

My ending thought for the career field is…I hope I haven't screwed this up! The last three years have really been a challenge…it's not the people or the career field but trying to do a really important "additional duty" while

News

BSC 40th

We need your help! The PT/OT committee for the 40th BSC Anniversary on the history of the professions in the AF needs your information. They want any photos of OT/PT during deployments, training exercises, etc., and any publications (books, journal articles, chapters, etc.) by OT/PT. Please send info to the following POCs:

OT History: Capt Ramesh Persaud
OT Photos: SMSgt Jennifer Kurth
OT Articles: Maj Sarah-Ann Beal

PT History: Maj Ramil Ascano
PT Photos: Capt Kendra Warner
PT Articles: Maj Jan Allen

Greetings from the schoolhouse!

I am writing to tell you about the awards garnered by Air Force physical therapists at the Texas Physical Therapy Association annual meeting last weekend. The Air Force PTs had quite an impressive showing, sweeping top honors for each of the major research awards!
*Lt Col Rob Wainner won the award for Outstanding Researcher of the Year
*Maj John Childs won the award for the Best Platform Presentation (presentation of his dissertation work)
*Lt Victoria Leake won the award for the Best Poster Presentation (presentation of her group's research project from our Baylor program)
Additionally, Lt Jennifer Pulliam was one of only 8 speakers who were selected to deliver a platform presentation from more than 35 applicants. She did an outstanding job, earning very high marks for presenting her Baylor group's research project.
Congratulations to each of these Air Force officers for their impressive accomplishments!

Best regards,
Thomas G. Sutlive PT, PhD, OCS
Lieutenant Colonel, USAF

Words From Past Consultants

Col Eva Eckburg

I continue to wear 5 hats, just now they are all at WHMC and I can slow down a bit. I am the Physical Medicine CC, Wing Sr. BSC, Chairperson, Staff Effectiveness Committee, BSC rep to the Wing Board of Directors and Human Resources Committee ... and get the joy of seeing patients!

Today's AFMS is in flux and some times it appears we (PT/OT) may be low hanging fruit for outsourcing BUT we are proving ourselves in the deployment arena. Just today I was informed that Air Staff approved an additional PT for deployment. Our therapists are seeing 30-45 patients a day and are first line providers, ordering x-rays etc and making the initial call on patient care. This is right in line with my vision and it is really great to see all this come to fruition! Folks like Maj John Childs and Maj Michael Ross as well as Lt Col Rob Wainner ensure what we do is research-based and many of you in the field are helping with those research projects. Just last week, Rob won the Outstanding Researcher of the Year Award, John won the award for Best Platform Presentation and Lt Victoria Leake won the award for the Best Poster Presentation. We are doing great stuff and I am very proud to be a part of and watching our Air Force future only get brighter.

As we prepare for our readiness role, we can not slight our responsibilities at home. Those that have served before us deserve our best. We need to continue to work smarter and not harder. Be vigil with your templates, ensuring the right mix of patients so you can get the best bang for the bucks for your departments and the patients. Do not forget why you went into Physical Medicine, it takes a certain person to do our job.

You are the greatest of the Air Force's assets and I continue to be proud of your accomplishments and how you represent the United States Air Force.

Col (Ret) Mary Ann Sweeney

My husband, Terry, and I stayed in the Annapolis, Maryland area after my retirement in October, 1995. I took a couple of months off, then went back to what I always liked to do - practicing Physical Therapy. Have to admit, I wanted nothing to do with administration, only patient care. I worked for Johns Hopkins Hospital, trying home care from 1996 to 1999. There I became Hospice trained, and worked a lot of end of life issues. Eventually I moved to our local community hospital - Anne Arundel Medical Center, and have been there for 5 years. Currently, I manage rehab in the Joint Replacement center. We do about 900 total joints a year - a lot for a small hospital. There is a unique program centering on group therapy, and we juggle 25 to 30 patients a week thru the program. I do some consulting to other hospitals on how to set up a Total Joint Program like ours. Also, mentor new grads, and work as clinical a instructor for PT and PTA students.

Terry and I hope to really retire in the next 5 years (that means going to real part time work). Our two children are in the area - the youngest is a senior in college, talking about grad school, the oldest is working and self-sufficient. For fun, I train/ride my horse, play on the Chesapeake Bay (yes, we have a boat), garden, and travel with my husband. The best part of having friends all over the world, is you get to visit them!

My knowledge of my Air Force colleagues is limited to what I see in the APTA literature. I read with great interest, the wonderful accomplishments of all the military professionals, and realize how challenging your work is in today's environment. I can tell you that I miss the professionalism, commitment and level of expertise the Air Force Physical Therapists avow and am very proud to be part of that history of dedicated excellence. I recall with great fondness how we would challenge each other and work as a committed team for the good of all we served.

Col (Ret) Jerry Arledge

Col Arledge was the Associate Chief from 1985 to 1988, retiring in 1988 out of Andrews AFB. Currently living outside Dayton, Ohio, he works for Montgomery County Home Health two days/week, spending a majority of his time working with disadvantaged seniors. Col Arledge is 71 years young and attributes his longevity to remaining physically fit and spiritually grounded, working on both regularly.

Col Arledge feels AF PTs are the best group of PTs there are; stating they are better trained and have more opportunities to use that training than civilian PTs. Col Arledge's closing comments were directed to the

Iraqi Deployment

Major Brian Young

The Physical Medicine Clinic at the 332 Air Force Theater Hospital (AFTH) at Balad AB has been extremely busy since the AF took over the 31st CSH in mid Sep. In our first 30 days of operation, the clinic had close to 1000 patient visits, which averages over 30 patients a day. Our team consists of 1 PT, 1 OT and 4 PM technicians, and cover a 7 day workweek, 10-12 hour shifts. Generally, everyone gets 1 day off per week. Our case load is quite varied. It ranges from the typical chronic LBP to acute sports injuries. The majority of PT patients seen are low back pain from wearing 30 pound body armor, knee injuries (PFPS and internal derangements) and ankle sprains. The only modalities on hand are TENS, heat and ice. Having a strong background in manual therapy, exercise prescription and differential diagnosis are the skills I find most helpful. Besides seeing referrals from the EMEDS clinic and Army TMC's on base, we have troops convoy to us from outlying bases, and see a steady load of inpatients, mostly locals.

We support a post-operative wound care clinic for orthopedics and general surgery for local nationals here who have received surgical care at the AFTH, during which we order follow-up radiographs, remove sutures/staples, clean and dress wounds, and apply casts. We screen all orthopedic referrals sent to the AFTH and manage as many as possible at our level. Those requiring orthopedic intervention, i.e. fracture, knee drain, radiographs reviewed, etc, we then discuss with or pass to orthopedics for management. Our orthopedic surgeons are very grateful for the level of management that PT and OT has undertaken in this deployment to cover their caseload. This has allowed them to remain almost

On Your Mark, Get Set, Deploy!! OTs Role in a Deployment

Major Peter Reinhardt

Last June Wilford Hall received the tasking to take over a Combat Support Hospital from the US Army in Iraq. The facility was a trauma level hospital, but more interestingly had both PT and OT services. The orders were for the Air Force to take over the facility in September 2004, but with a deployment date in August. As such, many things took place and the manning levels were finalized in that we had projected one PT, one OT and three PMTs. Wilford Hall would support the therapist positions and one PMT for the first cycle. The other two PMT slots would be filled by other Air Force assets. In the coming weeks many things took place which included last minute training, getting desert uniforms and numerous immunizations.

Finally, we deployed on 30 August 2004 and twenty-four hours later we were in Kuwait. At that point, we waited until we were able to get a C-130 flight into Balad Air Base. Following our arrival, we were acquainted with the base and the larger Army post LSA Anaconda. LSA stands for Logistical Support Activity as it is the hub for supplies/equipment in the Iraq theater. Balad AB is the smaller component as the Army has over 20,000 soldiers within LSA Anaconda, but the Air Force section is within the boundary of Anaconda.

Within weeks there was a TOA (Transfer of Authority) between the Army and the Air Force and the hospital's name was changed to the 332 Air Force Theater Hospital. During this time, both myself and Major Young (PT) became very familiar with the processes of care that the Army established. These processes have changed to allow smoother patient flow and care as well as improved efficiency. In that, the type of care has broken down into two components: inpatient and outpatient care.

Inpatient care is for US/Coalition Forces, Civilians involved due to coalition actions and Enemy Prisoners of War. The US/Coalition Forces are the smallest section as they typically are flown to Germany very soon after they are medically stabilized. The larger components are the Iraqi civilians and Enemy Prisoners. It soon became clear in this environment that our role was not very different from what it would be working in a US hospital. From the OT side, we performed splinting for trauma situations as well as general PROM exercises and strengthening. The length of stay for the inpatients varied depending upon an individual's injury, but most civilians would go directly home and the prisoners would go to prison. Types of injuries also varied wildly from IED (Improvised Explosive Device) injuries to burns from car bombings. Patient's ages ranged from small children to the elderly. I was very glad I had enough orthopedic pediatrics experience to treat the children.

The next and more involved category was the outpatients. We basically treated all the active-duty population not only at LSA Anaconda/Balad AB, but also the Army and Marine FOBs (Forward Operating Bases) in Iraq. The hospital was considered 3rd echelon care and so many patients arrived either via helicopter (many arrived throughout the day and night) or by truck convoy. The hospital had two Orthopedic doctors who were extremely busy with surgeries and, as a result, could not perform in a clinic setting without sacrificing patient's surgical needs. As both PT and OT have expertise in musculoskeletal evaluations, the role of the orthopedic screening was placed onto PT and OT. It was then decided that PTs role would be all spinal and lower extremity problems and OT would assess all upper extremity issues. Shoulders would be handled by both based on who had faster availability.

The next new issue that came up was the Iraqi outpatients. These

Iraqi Deployment (cont)

We have had 2 mass casualty situations thus far. Our team has filled the roles of manpower to bring litters off choppers, wheel litters to the OR, wash and dress wounds that are waiting surgical debridement, and making sure orthopedics has all the radiographs on patients they triaged so no fractures or foreign bodies (bullets/shrapnel) are in joints . We look for any opportunity to assist however we can.

We do get incoming mortars and rockets, about 2-3 times a day. Most hit far away from the hospital, although they may not sound too far away. On the other hand, it isn't too isolated out

On Your Mark, Get Set, Deploy!! OTs Role in a Deployment (cont)

Major Peter Reinhardt

Soon it became obvious that a therapist schedule would not be possible due to the unpredictability of the flying and convoy patients. I had realized that our clinic had to adjust to becoming more of an urgent care clinic rather than the standard Physical Medicine clinic we were used to. Once we made this mental jump, the process became much easier. Triaging patients was routine and our overall efficiency improved. In addition, we started using the Casting Tape that had been practiced at Wilford Hall for the previous year.

The Casting Tape was a huge jump in capability that the Army did not have. The previous OT had used thermoplastics, but due to the high temperatures in Iraq it was not easily utilized. The high temperature for this past summer in Balad was 138 degrees. The casting tape was useful for both the inpatients and outpatients and has already proven its worth. The thermoplastics still have their place, but the material of choice in Iraq is the casting tape as it is easier to make a splint as well as it is cooler for the patient to wear. The only drawback was that we came with only one technician with splinting experience. This required significant training to ensure all the technicians had similar skill levels.

Besides training with the casting tape, we have seen that both therapists and technicians need more training in non-traditional areas. These areas include: wound care, suture/staple removal, needle injection preparations for doctors and finally fiberglass casting of simple casts. These skills are vital in this environment not only for day to day patient care, but also for mass casualties.

In the two months we have been here we have had only one true mass casualty experience in which multiple patients came in on helicopter due to a mortar attack. (I am not allowed to give the total number for security reasons.) It was an amazing experience in that we immediately closed the clinic and the technicians were used as manpower, moving patients, and myself and Maj Young went into the emergency room. Our role was immediate wound care. We would also assess injuries and forward our suspicions onto the providing physicians. It was just like CMRT/MURT training and I was glad I had

See http://www.af.mil/news/story.asp?storyID=123009010 for

Army Articles on Combat PT/OTA

The full text for the abstracts below are at the following link: http://das.cs.amedd.army.mil/PDF/J04_7_9.pdf.

"Physical Therapists in Combat Health Support: History and Rationale for Army Transformation (Part 1)"

Majors Matthew B. Garber & Richard E. Baxter

The profession of physical therapy has its origins in the Army when "reconstruction aides" were utilized to rehabilitate injured Soldiers in World War I. Physical therapists (PTs) in the military took on a larger role as orthopedic physician extenders during the Vietnam War. The PTs also deployed during the Gulf War from 1990-1991. Since the end of the Gulf War, PTs have deployed in support of a number of support and stability operations (SASO), including Bosnia and Kosovo. In 1999, the U.S. Army Special Operations Command (USASOC) received authorizations for a PT in each active component Special Forces Group, Ranger Battalion, and Special Operations Aviation unit. Despite historical data demonstrating the effectiveness of PTs deployed across the spectrum of military operations, many AMEDD and Department of the Army leaders remain unaware of the contributions PTs can make outside the traditional hospital setting. This article will review and discuss the unique qualifications PTs possess as specialists in musculoskeletal medicine, as well as the implications of data from published papers, after action reports, and official military correspondence.

"Physical Therapists in Combat Health Support: Recommendations for Employment (Part2)"

Majors Richard E. Baxter & Matthew B. Garber

As described in Part I of this article, physical therapists (PTs) in the Army make a unique contribution to the military health care team. Their proven ability to independently manage musculoskeletal conditions, thereby allowing physicians and surgeons to focus their efforts on more complicated or surgical cases, also decreases lost duty days due to injury; reduces costs due to evacuation requirements; and increases return to duty rates. Currently, a PT is allocated to echelon III in the Combat Health Support (CHS) system. This article examines the factors governing employment of PTs and recommends the optimal strategy for their employment within the CHS system in support of Army divisions. After examining the relevant factors, the authors recommend assigning a PT to echelon II in the CHS system. Under this model, each forward and main support medical company supporting maneuver brigades and divisional troops, would have a PT organic to the unit. Such a model would optimize the capabilities of PTs to enhance unit readiness, while minimizing cost. Several implementation strategies for utilization of PTs within echelon II are also discussed.

"The Role of the Occupational Therapist in CSC Operations"

LTC Steven M. Gerardi & MAJ Sharon M. Newton

The role of the occupational therapist (OT) in Army Combat Stress Control (CSC) is to evaluate the occupational performance of Soldiers adversely affected by combat stress reactions and to implement interventions to enhance performance. The OT employs unique core occupational therapy skills as well as shared

News from the Outside

From the APTA
(http://www.apta.org/Bulletin#76869)

Medicare Announces Case Management Demonstration

The Centers for Medicare & Medicaid Services (CMS) is initiating a new demonstration project to identify ways to improve care for Medicare beneficiaries with high medical expenses while reducing costs for the patient and the program. The demonstration announced last week will study various case management models, including structured chronic care programs, intensive care, and increased provider availability, for high-cost patients in the traditional Medicare fee-for-service program. Physician groups, hospitals, and integrated delivery systems are being encouraged to submit proposals for participating in the demonstration.

"Manipulation of the Spine to Correct Subluxation" Ruled a Physician Service

The American Chiropractic Association's (ACA) legal efforts to secure recognition of chiropractors as the exclusive providers of "manipulation of the spine to correct a subluxation" under the Medicare+Choice program received a serious setback recently when Judge John Garrett Penn of the United States District Court for the District of Columbia granted summary judgment in favor of the defendant, Tommy G Thompson, Secretary of the US Department of Health and Human Services (HHS). Under Judge Penn's strongly worded ruling, the relevant statute clearly establishes that "manual manipulation of the spine to correct a subluxation" is a physician service that doctors of medicine and osteopathy can provide and be reimbursed for under Medicare. In the words of Judge Penn, the ACA's contrary position "invites an absurd result." In April, 2001, APTA filed a petition to intervene in this legal action as a defendant on the side of Secretary Thompson. APTA's efforts were directed toward rebutting Count II of the ACA complaint, which specifically raised the question of whether, under the Medicare statute, physical therapists are authorized to perform a "manual manipulation of the spine (to correct a subluxation)," but which also raised questions regarding physical therapists' uses of manipulation in general. In an updated Operational Policy Letter (OPL #23) of January 15, 2002, HHS clarified that "manipulation of the spine (to correct a subluxation)" is a physician service that can be provided only by physicians. The OPL also stated that Medicare+Choice organizations "may continue to use physical therapists to treat enrollees for conditions not requiring physician services as defined in section 1861 (r) of the Social Security Act." In its briefs, which the government said were consistent with the OPL, the government stated that

News

2004 Retirees

Maj Teagle, Thomas Retired Jan 04
Lt Col Miller, Julie Retired Jan 04
Capt Marks, Michael Retired Nov 03
Lt Col Smith, Beryl Retired May 04
Maj Holcomb, Winifred Retired Sep 04
Lt Col Domenech, Manuel Retired Jul 04
Lt Col Gilmore, David Retired Jul 04
Lt Col Sargeant, Patricia Retired Aug 04

Updated PM Roster

TSgt Sebastian Zablan and Joseph Bevins have put a lot of effort into updating the PM roster on the website. As of today they have updated all the changes they have received. If you have more changes or your previous updates were not taken care of or you have changes in the future, please send the information in an email to TSgt Sebastian Zablan at sebastian.zablan@nellis.af.mil. These changes will be input the first week of every month.

Upcoming Attractions in Future Issues

1. Letters from previous OT consultants
2. FDIS Physical Medicine
3. Info from the most recent NMSE course
4. Your suggestions

News report from Iraq.wmv

We Need your help!

We want to know how this newsletter can better serve physical medicine in general and you in specific. Please email any suggestions, comments or

Double-click on above box for the lighter side of the war in Iraq. (You may need to adjust your volume to make it work.)

Defining AFPM: An Offensive Vision for the Future

Maj John D. Childs, PT, PhD, MBA, OCS, FAAOMPT
Senior Physical Therapist and Director of Research, Wilford Hall Medical Center

Introduction

Although I must admit I am not usually one for reflection, I suppose doing so every now and then is probably useful to remind us where we have been and better inform our future direction as Air Force Physical Medicine (AFPM) healthcare professionals. Unfortunately, the hectic pace of our lives -- clinical practice, additional duties, PCS moves, operations tempo, training requirements, and any number other responsibilities at both work and home -- makes it easy to proceed through our career with tunnel vision, limiting our ability to appreciate how what we do fits in to the bigger picture of the Air Force Medical Service and the Air Force in general. One of the factors that contribute to this tendency is that within our AFPM community, we do not share a common chain of command. Most of us work for Wing Commanders at bases all over the world, each of which contributes uniquely to the Air Force mission. Although we still have a framework through the Biomedical Sciences Corps that represents our “professional chain of command”, our distinct mission requirements and sometimes divergent priorities make it inherently more difficult to achieve our common purpose within AFPM.

Despite these organizational hurdles, AFPM leadership all over the world regularly confronts pressing considerations related to our quality of care, productivity, cost-effectiveness, readiness roles, etc. These issues are used by key decision-makers as benchmarks to establish our collective value to the Air Force Medical Service and Air Force as a whole, making it incumbent upon us to define who we are as evidence-based practitioners within the healthcare delivery process. Phrased in a variety of ways, the question is usually asked something like, “What does a uniformed physical therapist or occupational therapist offer that cannot be provided by civilians?” These types of questions have been directed for many years to almost all healthcare-related disciplines within the Air Force Medical Service. Although hearing these types of questions may be unsettling at times, they are for fair questions to ask. As taxpayers, should we not ourselves advocate that our services be contracted out if the Department of Defense can successfully accomplish the full spectrum of our mission both here at home and in the deployed setting? Unfortunately, when these inquiries come, it is easy to find ourselves unprepared and on the defensive. How many times have we tried to understand the proverbial “bean count” and how it impacts our staffing levels? It’s easy to spend many well-intended hours pouring over reams of data to explain yet again that the “numbers” are not an accurate reflection of our true productivity. In some cases, that may be accurate. In other cases, our productivity may well be suboptimal. Either way, we must be vigilant in our efforts to insure our productivity is consistent with an acceptable standard and that our efforts are accurately reflected within the various systems used to measure productivity. But is this the whole story of whether we belong in uniform?

Taking the Offensive

Although productivity is a key indicator that will to some extent define our viability as AFPM professionals, it is by far not the only one. I cannot speak for everyone, but I would suggest that an offensive strategy to define the vision for our future will ultimately be a more potent strategy to convince the Air Force leadership as to our vital role in the military healthcare system. In fact, the current landscape within the Air Force Medical Service offers us unique opportunities to do just this. For example, we have seen over the last couple of months how our deployed AFPM personnel have taken the offensive and rapidly defined our capabilities in the deployed setting under frequently austere and hostile circumstances. They are seeing

Defining AFPM: An Offensive Vision for the Future (cont)

Major John Childs

Taking the Offensive in Clinical Research

Another area where AFPM has been able to successfully take the offensive in defining our value to the Air Force is in the area of clinical research. Many individuals may be familiar with some of the ongoing research efforts; however, others may not be. Again, reflection is helpful to illuminate the bigger picture of where we have been and where we are going. Over the last 6-7 years, an incredible amount of military relevant clinical research pertinent to AFPM has been published in a variety of peer-reviewed rehabilitation and medical journals throughout the world. These efforts have largely been responsible for much of the current emphasis on evidence-based practice within our profession. Results from many of the efforts (outlined in further detail below) have established best practice patterns, the application of which has been associated with improvements in outcomes of care, satisfaction, costs, and less future healthcare utilization among our military healthcare beneficiaries. There is no central repository to compare the research productivity across healthcare professions within the Air Force Medical Service, but I can assure you that few professions have been as productive. As an example of the breadth of ongoing clinical research throughout the AFPM community (and at the risk of almost certainly omitting a facility that should be included), a list of Air Force military treatment facilities that have recently been or are currently participating in ongoing research is included below:

Andrews AFB (MD) Barksdale AFB (LA) Columbus AFB (MS) Dyess AFB (TX)
Eglin AFB (FL) F.E. Warren (WY) Kessler AFB Kirtland AFB
Lackland AFB (TX) Los Angeles AFB Luke AFB (AZ) McDill AFB (FL)
Minot AFB (ND) Nellis AFB (NV) RAF Lakenheath (UK) Randolph AFB
Travis AFB (CA) Wright Patterson AFB (OH) U.S. Air Force Academy (CO)

Obviously, facilities don't perform research – People do! Below is a list of our active individuals in the AFPM community who have been recently involved in clinical research at these facilities. Again, the only thing I can virtually guarantee is that I have omitted someone whose name should appear.

Capt Andrew Bennett (separated) Capt Mike Blowers Capt David Browder Maj John Childs
Lt Col(ret) Tony Domenech Capt Mike Fink Capt Al Goodnite Maj Randy Green
Capt Ben Hando Capt Nicole Henkleman Capt Scott Jones Maj Kevin Johnson
Capt Evan Kelley Capt Brian Langford 1Lt Victoria Leake Capt Christian Lyons
Capt Ismael Magtoto Maj Guy Majkowski Capt Justin Martin Capt John McGee
Maj Gerald McGinty Capt Cory Middel Capt Denis Nolan Capt Matt Ostler
Capt Trevor Petrou Capt Maria Pugia 1Lt Jennifer Pulliam Maj Joel Robb
Maj Michael Ross Capt Jeremy Skabelund Lt Col Jeanne Smith Capt Michele Vita
Maj Mara Weichsel Capt Marie West Lt Col Bob Wenner

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2. Browder DA, Erhard RE, Piva SR. Intermittent cervical traction and manipulation for the management of cervical compressive myelopathy attributed to cervical herniated disc. *J Orthop Sports Phys Ther*. In press.
3. Childs JD, Fritz JM, Flynn TW, Irrgang JJ, Johnson KK, Majkowski GR, Delitto A,. Validation of a clinical prediction rule to identify patients with low back pain likely to benefit from spinal manipulation. *Ann Int Med*. In press.
4. Childs JD, Fritz JM, Piva SR, Whitman JM. Proposal of a classification system for patients with neck pain. *J Orthop Sports Phys Ther*. In press.
5. Childs JD, Piva SR, Fritz JM. Responsiveness of the numeric pain rating scale in patients with low back pain. *Spine*. In press.
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1. Effectiveness of manual physical therapy and exercise for lumbar spinal stenosis: A prospective, randomized controlled clinical trial
2. The effectiveness of an extension-oriented intervention in patients with low back pain: A randomized clinical trial
3. Validation of a clinical prediction rule for identifying patients likely to benefit from a lumbar stabilization program
4. Association between impairments and function in response to physical therapy in individuals with Patellofemoral Pain Syndrome
5. The relationship of strength and flexibility of soft tissues related to the hip and the presence or absence of Patellofemoral Pain Syndrome
6. The effectiveness of thoracic spine manipulation on success rate, disability, function, impairments in patients with neck pain: A randomized clinical trial
7. Development of a clinical prediction rule to identify patients with neck pain likely to benefit from thoracic spine manipulation
8. Preferential activation of the transversus abdominus muscle during core lumbar stabilization exercises
9. Long term effectiveness of the Army's running shoe program
10. Electromyography and neuromuscular electrical stimulation for +Gz training and endurance
11. The effectiveness of subtalar joint manipulation in improving function and reducing pain for Grade I-II inversion ankle sprains
12. Comparison of two spinal manipulations for the treatment of low back pain as measured by patient self-reports of pain and function: A randomized clinical trial

Translation of Evidence into Practice

There is nothing wrong with classic laboratory science that seeks to understand underlying mechanisms for how a particular treatment works, for example. This type of work can lead to innovative solutions that revolutionize the way a particular condition is diagnosed or treated. However, the downside of this type of research is that many years often pass before the efforts are relevant to healthcare practitioners who need answers for the patient they are seeing today. This is exactly where we fit in. The unique feature among the previous and ongoing research efforts is that almost all of the studies have immediate implications for today's warfighter in the diagnosis, prevention, and treatment of musculoskeletal conditions. When this evidence is published by military healthcare professionals, our exposure is elevated throughout the military healthcare system in such a way that our contribution to the overall care process becomes self-evident. Few words need to be spoken, simply letting the evidence speak for itself. For example, to offer another perspective on our contribution in the area of clinical research, all one must do is examine the list of authors in an upcoming special issue on manual therapy being published in *JOSPT* in November. Every paper has at least one author in AFPM! These efforts afford us unique opportunities to showcase what we bring to the table as military healthcare professionals. The list of papers and authors for the upcoming special issue is included below.

1. The Influence of Experience and Specialty Certifications on Clinical Outcomes for Patients With Low Back Pain Treated Within a Standardized Physical Therapy Management Program (Julie M. Whitman, Julie M. Fritz, John D. Childs)
2. Clinical Hip Tests and a Functional Squat Test in Patients With Knee Osteoarthritis: Reliability, Prevalence of Positive Test Findings, and Short-Term Response to Hip Mobilization (Amy V. Cliborne, Robert S. Wainner, Dan I. Rhon, Coy D. Judd, Terrance T. Fee, Robert L. Matekel, Julie M. Whitman
3. Proposal of a Classification System for Patients With Neck Pain John D. Childs, Julie M. Fritz, Sara R. Piva, Julie M. Whitman
4. Intermittent Cervical Traction and Thoracic Manipulation for Management of Mild Cervical Compressive Myelopathy Attributed to Cervical Herniated Disc: A Case Series David A. Browder, Richard E. Erhard, Sara R. Piva

Defining AFPM: An Offensive Vision for the Future (cont)

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Future Directions

Ultimately, the effectiveness of our research will be judged based on the extent to which the finding have implications for improving the care of our Airman, Soldiers, Sailors, and Marines. Let's take back pain as an example. Next to the common cold, the complaint of LBP is the most common reason individuals visit primary care.[3] Within the Department of Defense, low back pain is one of only two diagnoses (the other being respiratory infections) in the top ten categories for both medical encounters and hospital bed-days, accounting for 382,000 healthcare visits and 12,000 hospital bed-days annually.[1] Chronic, disabling episodes of LBP are the #1 condition that brings about a medical board, with lifetime direct compensation costs reaching into the billions of dollars.[5] In the Air Force, discharge rates increased nearly 80 percent from 1990 to 1994. In the Army, 270 out of every 10,000 are discharged each year with back pain complaints in 2002. Uniformed service members with back pain have the highest risk of disability 5 years after injury than any other single medical diagnosis.[4] The logical question is, "How are ongoing research efforts impacting this epidemic in the military healthcare system?" As an example, an upcoming publication in *Annals of Internal Medicine* will highlight the power of a clinical prediction rule to accurately identify patients with back pain likely to benefit from spinal manipulation and improve outcomes of care and costs over the long-term.[2]

Many active duty AFPM professionals were involved in the completion of this project. Prior disclosure concerns preclude sharing the details of the results in a public forum; however, the results will likely have profound implications on establishing our role in the immediate management of patients with acute low back pain in the military healthcare system. Many future studies are being planned with similarly profound implications for the prevention and treatment of musculoskeletal conditions among our uniformed service members.

There are many examples, but some of the current research efforts are outlined below.

1. "A Randomized Trial of Low Back Pain Prevention During Basic Military Training", Peer Reviewed Medical Research Program, Department of Defense Congressionally Directed Medical Research Programs ($2 million)
2. "Overcoming Obstacles to Recovery: A Randomized Trial of a Cognitive Behavioral Intervention for Primary Care Patients with Low Back Pain", National Institute of Arthritis and Musculoskeletal and Skin Diseases, National Institutes of Health ($6 million)
3. "Implementation of a Spinal Manipulation Clinical Prediction Rule into the Primary Care Management of Patients with Low Back Pain", Peer Reviewed Medical Research Program, Department of Defense Congressionally Directed Medical Research Programs ($2 million)
4. "Development of an Interactive Educational DVD for Patients with Low Back Pain in Primary Care", Center of Excellence for Medical Multimedia ($300,000)

Conclusion

As with many of the previous and ongoing efforts, many AFPM professionals will collaborate to accomplish projects that could never be accomplished by the efforts of a single individual. The synergistic effects of our collaboration will continue to have considerable implications for how AFPM is to an extent that demands our services as autonomous practitioners within the military healthcare system.

These are indeed exciting times that afford us unique opportunities to define who we are. However, our future success will depend to some ability to [illegible] AFPM is simply incumbent to help others see what seems so obvious to us." Move ahead, move fast

Have a Happy Holiday Season!

"When you hear hoofbeats, think horses before zebras." Anonymous